September 30, 2010

The Honorable Kathleen Sebelius
Secretary
Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, D.C. 20201

Dear Madam Secretary:

Re: Affordable Care Act (ACA), Administrative Simplification: Health Plan Identifier

The National Committee on Vital and Health Statistics is the statutory advisory committee with responsibility for providing recommendations on health information policy and standards to the Secretary of the Department of Health and Human Services (HHS). The Patient Protection and Affordable Care Act (ACA) enacted on March 23, 2010, calls for the Secretary to promulgate a final rule to establish a unique health plan identifier (HPID) based on the input of NCVHS.

A unique national plan identifier was originally called for under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Subtitle F–Administrative Simplification. The purpose of the original Administrative Simplification provisions was to "improve the efficiency and effectiveness of the health care system, by encouraging the development of a health information system through the establishment of standards and requirements for the electronic transmission of certain health information." These provisions included requirements for the adoption of standards for transactions and code sets and standard unique identifiers for individuals, employers, health plans, and health care providers. To date, federal regulations have been issued to address the transactions and code sets, and to adopt a national standard unique identifier for employers and for health care providers. Regulations for a standard unique identifier for health plans have not yet been adopted.

To understand the issues associated with an HPID, NCVHS contracted for an environmental scan to be conducted (see Appendix A for the Environmental Scan, also available at www.ncvhs.hhs.gov) and held hearings on July 19-21, 2010. A wide range of stakeholders provided in-person or written testimony,

including health plans, provider organizations, health care clearinghouses, pharmacy industry representatives, standards developers, professional associations, representatives of Federal and State public programs, the Workgroup on Electronic Data Interchange (WEDI), and individuals with specific HPID proposals. Testifiers described a number of key characteristics, features, uses and needs for an HPID, including being able to correctly route transactions; reduce the cost of managing financial and administrative information; improve the accuracy and timeliness of claims payment; and reduce dissatisfaction among providers and patients/members by improving communications with health plans and their intermediaries. While testifiers described their needs from different perspectives, all who stand to be impacted by the HPID observed it is important to ensure that the new identifier can be used in existing standard transactions. There was also consensus that the enumeration, maintenance, and use of the HPID be kept simple, but robust enough to achieve the desired impact and ensure a smooth transition.

Pertinent to the discussion of a unique health plan identifier is the definition of "health plan." The original HIPAA legislation (P.L. 104-191) and subsequent regulations (45 CFR Part 160.103) provide a definition for health plan. That definition includes references to entities responsible for payment of claims for health care services and to policies or contracts between an entity and individual specifying benefit coverage. In the context of health plan enumeration, this range exemplifies the multiplicity of purposes for health plan enumeration. At the most basic level, a provider needs to be able to identify the entity that should receive queries about an individual's eligibility for coverage, and the entity to which a request for payment should be sent; in other words, the entities that must be identified in a standard eligibility or claim transaction.

However, actual practice shows that health plans come in a variety of types, forms and arrangements through which they perform and deliver their services. These include health plan components that represent varying lines of business or market segments such as medical, dental, property and casualty; types of products or categories of insurance programs such as PPO, HMO, indemnity, Medicare Advantage, Medicaid; specific products such as PPO Gold or Medicare Supplemental products; and group plans or contracts specific to a group. The above listing is provided for illustrative purposes and does not constitute the whole, or even a recommended taxonomy on what is to be enumerated. There is no gold standard definition for a health plan that can guide an enumeration process—and who or what needs to be numbered.

In today's market, a variety of administrative and processing intermediaries assist in the performance of financial and administrative transactions. These include, for example, rental networks that provide access to defined provider networks; benefits managers; third party administrative service providers, repricers and others. These intermediaries may not be health plans in the traditional sense, but they have evolved to fulfill roles of a health plan, and are relevant to the content and transmission of HIPAA transactions. These entities often need to be identified in the transaction for successful, efficient communication. Enumeration of these entities is important as they may be the actual

recipients of provider queries or claims rather than the health insurance issuer or other entity ultimately responsible for payment.

The committee recognized that there are many other implications for a health plan identifier. For example, on a more complex level than described above for standard transactions, purchasers of health insurance may wish to monitor the performance of the issuers of products and policies using a unique identifier for those entities. Such monitoring, though not accomplished through the use of the HIPAA standard transactions, may be achieved in other ways using an identifier. The information might be analyzed by employers, public programs a health insurance exchange or by insurance commissioners.

With respect to its charge in the ACA, and based on the testimony (see Appendix B for list of testifiers and commenters), NCVHS has developed a set of nine observations and recommendations as input to the Secretary for adopting a standard national unique HPID. Observations and recommendations are provided on (1) definitions and entities eligible for enumeration with an HPID , (2) levels of enumeration, (3) the format and content of the HPID, (4) the directory database to support the HPID, (5) the pharmacy industry use of the HPID, (6) the implementation process and timing, (7) applicable testing of the HPID enumeration process, (8) use of the HPID on a health plan identification card, and (9) improving the use of standards and operating rules in support of HPID purposes:

1. **Observations for definitions and types of entities eligible for enumeration with an HPID:** While testifiers urged simplicity in the identifier, there was also urgency for assuring that appropriate products be enumerated such that applicable communications could be facilitated. In other words, a health plan may have one or more HPIDs – one for itself, and one for each of its products. Intermediaries would also be able to obtain their own HPID.

   Recommendations – HHS should:

   1.1 clarify the definition of health plan as specified in the HIPAA regulations (45 CFR Part 160.103) for purposes of HPID eligibility and enumeration, including that property and casualty insurers and workers' compensation plans could be eligible for such enumeration even though they are not covered entities.

   1.2 work with stakeholders to reach consensus on names and definitions for intermediary entities. Consider making these intermediary entities eligible to obtain an HPID where there is a clear use case for them to be enumerated.

   1.3 request stakeholder input through groups such as Workgroup on Electronic Data Interchange (WEDI), America's Health Insurance Plans (AHIP), National Association of Insurance Commissioners (NAIC), and the Designated Standards Maintenance Organizations (DSMO) Committee for definitions of

products to be used in plan enumeration by October 31, 2010 (or other date as feasible by CMS).

1.4 collaborate across Federal agencies and departments to develop or identify consensus definitions affecting the identification of health plans, including Indian Health Service (IHS), Department of Veterans Affairs (VA), Department of Defense (DoD), and the Federal Employee Health Benefit Program (FEHBP).

1.5 coordinate, to the maximum extent feasible, the development and implementation of the HPID with other plan related requirements in the Affordable Care Act, including, for example, the consumer health insurance web portal, the health insurance exchanges and the regulatory requirements for health plans.

2. **Observations relating to levels of entity enumeration:** The NCVHS observes that the HPID should fulfill the original intent of HIPAA to improve the efficiency of the health care system by adopting standards for electronic exchange of health information. As such, the HPID enumeration process needs to ensure that the right entities (including at least the transaction recipient, administrator, and financially responsible party) are enumerated. Several years ago, CMS defined the National Payer ID, pre-HIPAA, as "a system for uniquely identifying all organizations that pay for health care services;" noting this was also known as Heath Plan ID, or Plan ID. At that time, there was much discussion about the value of using plan product information, such as the levels of indemnity, PPO or HMO coverage – high, low, silver, gold, etc. These terms may still have relevance in the enumeration process to be developed by HHS.

Recommendations – HHS should:

2.1 initially enumerate all health plan legal entities as defined in the HIPAA legislation and further clarified in regulations at 45 CFR §160.103.

2.2 determine at what level, including product (benefit package) level or other categorization, a health plan should also be enumerated, using input from stakeholders, and identify these in regulation.

3. **Observations for format and content of HPID**: The NCVHS heard testimony from a wide range of potential users of an HPID. The health plan community encouraged the concept of a simple number, citing that industry had learned from the NPI experience how there were other ways to acquire needed information about providers other than through an identifier with embedded intelligence. The provider community is primarily interested in getting information needed to appropriately direct transactions, communicate with applicable entities, match payments to fee schedules, verify an individual's eligibility for health care services, and assist individuals in understanding their costs associated with the health care services to be received. While a few testifiers suggested some value of having embedded intelligence in the HPID, discussions during the hearings revealed that the desire

was for easy access to information – however that may occur. It was recognized that embedding intelligence in a HPID may add complexity and cost to the industry for maintenance of the number and ultimately limit its use for currently unanticipated purposes.

Recommendations – HHS should:

3.1 adopt an HPID that follows the ISO Standard 7812, with Luhn check-digit as the tenth digit.

3.2 adopt an HPID that contains no embedded intelligence.

4. **Observations for the directory database to support the HPID enumeration system and process**: As any enumeration process will require collection of information associated with who or what has been identified, a directory database will be necessary to support information on entity demographics and other relevant identifying facts. The extent to which the database contains additional information useful in identifying entities associated with each plan, provider contract, etc. is subject to (1) what entity level is enumerated, (2) the extent of burden to maintain the database, and (3) the reliability of the data over time. At a minimum, there should be rules associated with the database concerning who or what may be enumerated, the minimum required data to be expected from entities, what additional, optional data is to be collected, who may access the database, what data may be available to be accessed, the required frequency of updates, and other functions if any.

Recommendations – HHS should:

4.1 establish an HPID enumeration system and process supported by a robust online directory database.

4.2 direct CMS to work with stakeholders including other federal agencies to identify the minimum necessary data elements for the directory database. Consideration should be given to including the Employer Identification Number (EIN), Taxpayer Identification Number (TIN), National Association of Insurance Commissioners (NAIC) identifier, Source of Payment Typology, and other identifiers that may assist in supporting the need to appropriately identify health plans in administrative transactions and in the updating, development and/or effective use of standards and operating rules. The database should be sufficiently flexible to enable additional information to be added initially at the discretion of the entity, and potentially in the future, as a requirement by HHS.

4.3 require the entity enumerated to maintain all information according to a published schedule of updates or more often as appropriate, to maintain accuracy. If there are no changes at the time of a scheduled update, the

date information was validated should signify that the entity has reviewed and is confirming the data as being current.

4.4 make available appropriate information from the HPID directory database to support the efficient and accurate exchange of information.

4.5 consider, for the future, requiring that the HPID system enable electronic transactions with the directory database for users or their systems to obtain information and route transactions more efficiently and effectively.

5. **Observations specific to retail pharmacy implementation of HPID**: NCVHS heard testimony that retail pharmacy transactions utilize the RxBIN/PCN identifier to facilitate their transaction processing and that changing to another identifier would significantly impact existing data flows in the retail pharmacy industry which are currently working very effectively. As such, the pharmacy industry requested an exemption from the requirement to only use HPID in retail pharmacy transaction because of the current success with the RxBIN/PCN identifiers for routing purposes.

   Recommendations – HHS should:

   5.1 not require the HPID to be used in place of the existing RxBIN/PCN identifier in retail pharmacy business and transactions.

   5.2 require the use of HPID on the HIPAA-named standard transactions for retail pharmacy, where appropriately defined by industry through the ASC X12 and NCPDP processes.

6. **Observations for implementation and timing:** Smooth transitioning to the HPID was raised during the hearings as critical to be addressed. This was identified as especially acute for Medicaid programs currently using the NAIC identifier and the need for a separate identifier for Medicaid subrogation purpose. NCVHS also heard testimony concerning interest in grandfathering some existing ISO identifiers, but determined that the confusion in the industry that might ensue could be worse than the level of effort to make the change.

   Timing associated with industry compliance of the ASC X12 v5010 and NCPDP D.0 financial and administrative transactions was also identified as troublesome. Along with modifications to accommodate v5010 and D.0 of the HIPAA standards, adoption of the HPID will have an impact on systems. Plan and provider information systems will require updating including expansion of data fields to accommodate the HPID, and crosswalks between existing proprietary identifiers and the HPID. Clearinghouses and vendors will need to update their systems and create crosswalk identifiers. Health plans will need to retool their systems to accommodate the new HPID, determine entities to be enumerated, communicate their HPIDs to trading partners, and accept the new HPIDs as valid on the transactions they receive. The HPID will also impact information systems that involve HL7 standard protocols.

Testimony from HL7 observed that it is likely that a new HPID may require changes to existing scheduling, registration, pre-admission, admission, and other information systems and their screens, work flow, and data elements collected, stored, displayed, and processed by those applications. Potentially tens of thousands of existing interfaces could be impacted by this change.

Recommendations – HHS should:

6.1 consider that the effective date of October 1, 2012 be interpreted as the date to begin registering for an HPID. As such, subsequent phases should include time for enumeration and testing before a final implementation date when the HPID must be used in compliant transactions. This will ensure sufficient time for publication of the regulation and development of the enumeration system and process. Phases should include:

- October 1, 2012 – March 31, 2013: Enumeration
- April 1, 2013 – September 30, 2013: Testing
- October 1, 2013: Implementation

6.2 describe in regulation the potential purposes and uses of the HPID, including its uses in standard transactions, potential uses for health information exchange, and others. While purposes should not be restricted, the initial focus should be on enumerating entities for use in the financial and administrative transactions required under HIPAA.

6.3 accommodate bulk enumeration of HPID as applicable.

7. **Observations for testing:** Experience with the enumeration and adoption of the NPI has demonstrated that sufficient time must be allowed for testing, including the ability to conduct dual processing with both existing proprietary identifiers and the HPID.

Recommendations – HHS should

7.1 provide sufficient time and guidance for testing the HPID in transactions prior to use.

7.2 allow for a period during which dual use of legacy health plan identifiers and the new HPID is permitted in the transactions as appropriate.

8. **Observations for use of the HPID on a health plan identification card**: NCVHS acknowledges that there is significant usage of health plan identification cards in the industry today. There is an implementation guide for identification cards available from NCPDP (for pharmacy cards) and a recommended implementation guide for medical cards created by WEDI. Additionally, there is strong support for using the HPID in these health plan identification cards.

Recommendations – HHS should

8.1 encourage the use of the HPID in health plan identification cards.

9. **Observations relating to improving the use of standards and operating rules in support of HPID purposes:** Some testifiers indicated that much can be accomplished by increasing use of the financial and administrative transaction standards today, implementing appropriate operating rules, and ultimately incorporating what is needed in the standards. Each field in which an identifier is required by a health plan's companion guide should be identified and mapped to the level of entity required to be identified in the standard transactions. Enumerating each applicable entity and including applicable information in the HPID directory database should enable many provider and individual questions that arise in the course of processing transactions to be addressed. For example, when an 835 transaction is received by a provider, the provider should be able to identify the entity with which it has a contract and through use of the directory database may be able to reference the appropriate identifiers to then reference its applicable fee schedule to match the payment to the schedule. With the adoption of the HPID there needs to be clear instructions through operating rules and plan guidance documents for how to use the HPID in each field in each of the HIPAA transactions.

Recommendations – HHS should

9.1 strongly encourage the industry to collaborate to enhance operating rules for the financial and administrative transactions to support the use of the HPID.

NCVHS believes there is an opportunity created by the Affordable Care Act to increase adoption of health information technology tools to improve the effectiveness of the health care system. The industry has awaited a national health plan identifier for some time. As such NCVHS recommends that HHS implement these recommendations. NCVHS continues to stand ready to provide additional guidance or assistance to the Secretary on development of regulations for the HPID.

Sincerely,

/s/
Chairperson, National Committee
on Vital and Health Statistics

Enclosures:
Appendix A: Environmental Scan
Appendix B: List of Testifiers and Submitters of Written Testimony

Cc: HHS Data Council Co-Chairs